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AUTHOR Runquist, Merrell P.; Behar, Lenore B.
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ABSTRACT

This report describes some of the ethical and practical problems experienced by a group of mental health consultants attempting to initiate a primary prevention mental health program in a three-county area of North Carolina. Project Early Aid was designed to implement a program model that would upgrade both the interpersonal and physical environments of young children attending day care centers. It quickly became apparent to the consulting team that their values in regard to positive mental health were often discrepant from those of the caregivers who may or may not be reflecting shared values of a particular community. The resulting suggestions of the group on how to begin a primary prevention program include: (1) clarification of the belief systems concerning behavioral-emotional functioning of children to the consultants themselves, to coprofessionals, and to community members; (2) encouragement of the consumers' articulation of long-term goals and belief systems; (3) understanding of the historical factors at work in a community that have led to the establishment of and change in such belief systems; (4) a differentiation of those values which are widely shared and those which are idiosyncratic to certain persons or subgroups; and (5) an attempt to capitalize on points of convergence, while openly discussing divergent issues. (CS)

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PREVENTION OF MENTAL HEALTH PROBLEMS: MEETING NEEDS OR IMPOSING VALUES?

Merrell P. Runquist[1] Lenore B. Behar[2]

University of North Carolina at Chapel Hill

As is well known the mental health field has expanded at a rapid rate for a number of years. In spite of the fact that new practitioners are being added each year it has become apparent to many that there never will be enough trained personnel to treat all people evidencing emotional-behavioral disorder. Even if enough personnel were in the field, there is still no reason why clients would have to go through, perhaps years of distress, before presenting themselves for treatment. In response to the obvious gap between the number of available practitioners and the vast quantity of problems to be treated many professionals advocated increased attention be paid to models of intervention which emphasized prevention of disorder.

The most widely accepted model came to be that stressing primary, secondary, and tertiary prevention. Since the mental health system had for a number of years been engaged in secondary and tertiary prevention, the idea of primary prevention had the greatest appeal for the biggest long-term payoff even if the effects from applying this model would be far from immediate. In brief, the primary prevention model sought to reduce the incidence of new cases of behavioral dysfunction appearing in a defined population. Instead of the individual clinical case being the subject of interest, an aggregate of persons not yet manifesting symptoms of disorder became the focus of mental health interventions. Since it had long been

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[1]Merrell Runquist is an Instructor of Psychology in the Department of Psychiatry, University of North Carolina School of Medicine and is the Assistant Director of Project Early Aid of the Orange-Person-Chatham Mental Health Center.

[2]Lenore Behar is an Assistant Professor of Psychology in the Department of Psychiatry and is Director of Project Early Aid. Please address all inquiries concerning this paper to Merrell Runquist.

concluded that clinical manifestations of disorder had their roots in the early life of the individual it became quickly apparent that successful preventive efforts would have to be concerned with the young child, his caregivers, and his environment.

The question throughout the articulation of the primary prevention field was often "what to prevent?" Research and clinical study had revealed many facets of disordered behavior and most mental health professionals came to believe that the requisite knowledge was available to share with the community at large about what constituted good mental health, adaptive behavior, good child rearing practices and so forth. To many the idea of "prevention" was a concept more aligned with mental illness rather than mental health. Rather than preventing deficits the emphasis should be on enhancement of strengths. Whether interventions were intended to prevent, enhance, or prevent through enhancement the crux appeared to be that the professional community was imparting to the public a rather homogenous package of beliefs, attitudes, and values about what were the necessary conditions to produce mental health. Education for mental health was a broad effort to shape the behavior and beliefs of the public into a state of congruence with the professional community. Within the mental health field research was oriented to finding what was lawful, generalizable, and universal. While the researcher tried not to make value judgements concerning research outcomes, the practitioner who applied research findings often did, however implicit such judgement may have been.

In many instances, especially in primary prevention work, the application of values and attitudes as to what constitutes adaptive behavior or good mental health which were garnered from normative studies, too often failed to take into account the expectancies of a particular community or a sub-system within a community. Instead of working conjunctively with community members in articulating

what the goals and wishes are for the community's younger citizens, we too often rush in with a model for what they should be. When a lack of fit is perceived between what the mental health professional desires and what community members are doing we often attempt to overcome the "resistance" by utilization of various attitude change techniques. Interestingly, many of these techniques were derived through the use of the deception experiment in social psychology. Training in individual psychotherapy has led many of us to believe whenever a client does something at variance with our beliefs of what should occur he is exhibiting pathological behavior. However, when implementing a program of primary prevention it is important to bear in mind that the population does not come to us in overt distress, as in psychotherapy, but rather, we go to the population with a program defining both the problems and solutions. We often ask consumers to buy our program, either literally or figuratively, and we use our positions of socially sanctioned authority as the lever to insure compliance. When the community has difficulty accepting or making use of our proposals and services we speak of "creating a need" and then filling it. Needless to say this technique has been a tool of master propagandists for many years. It should not be assumed that the mental health professional ever has any malevolent intent in mind but one can easily slip into a posture of social control without becoming aware of it.

We came to our present state of ethical unrest through our work with a mental health program for children under six years known as Project Early Aid. The project began in the Fall of 1972 and serves three counties in central North Carolina. The project is a joint endeavor of the University of North Carolina and the Orange-Person-Chatham County Mental Health Center. The aim of the project is prevention and the population served are children maintained in day care centers, their teachers and parents. It was believed by us at the outset of the project that children in day care were both an accessible population for the mental

health professional and a high risk group for the development of behavioral disorders. To implement the goals of the project a team of full-time mental health consultants was assembled with professional backgrounds in social work, educational psychology, early childhood education and child development. The general aim of the program was to upgrade both the child's interpersonal and physical environment. This was to be accomplished through intensive consultation, both individual and group, to child care workers in 20 day care centers in the three county area. Each consultant provided a full day of service per week to each of four centers assigned to her. One day per week was reserved for interagency contacts, supervision, and staff meetings. The program allowed for the consultant to spend the morning working with individual teachers in the classrooms, assessing the ongoing programs and making suggestions for individual children or the group as a whole. In the afternoon the consultant would meet with the teachers in a group and instruct them in a course on child development and child mental health. It was arranged that teachers participating in the course received credit from a local technical institute. Other time was used for conferences with the child care center director on administrative issues, individual teacher conferences, and parent conferences. Our basic operating premise was that children were being cared for in situations that were not completely adequate to fully meet the childrens' needs and that through proper instruction in principles of good child rearing and positive mental health practices all child care workers could help their children achieve optimal levels of functioning.

At the outset of the program we paid a great deal of attention to the importance of relationship building between the consultants and the various day care center staffs. It was believed that through coming to know us as people, the center staffs would automatically begin to trust and would allow us to do what we wished to do.

Within a few weeks of program operation it became apparent to project staff that there was a great deal of variance in consumers perceptions of what the preventive program was about and their acceptance of it. Many day care teachers were utilizing the consultation in ways which we defined as quite acceptable, while some were engaged in a variety of reactions which we interpreted as avoidance behaviors. We were very concerned at that point that the program impact remain homogenous and that different people progress at the same rate. Much consternation took place within the project staff as to how to meet the problem of engaging "resistent" consumers in what we had to offer. We usually concluded that the "relationship" had not stabilized yet and that in the long run the clients would make satisfactory use of the services. Some of the greater discrepancies between the professionals' beliefs and those of the consumers included areas of: control of aggression, sex role stereotyping, role of parents in day care, and balance between structured and unstructured activities. In the area of aggression, for example, we found a wide latitude of approaches ranging from endorsement and use of corporal punishment to a posture of passivity or "let the child do his own thing".

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Over the course of time the project staff became quite conversant with the behaviors of the consumers and the degree to which they conflicted or agreed with our own beliefs, and how greatly we wanted the consumers to change. However, we remained largely out of direct understanding of the long standing beliefs, values and goals of both parents and teachers. During the weekly staff meetings we gradually began to articulate our own values and expectancies for ourselves and for those clients with whom we worked. While our intent was often to grapple with the issue of "why won't they let me do what I want to do?", we began instead to understand ourselves. We saw more clearly that each person's values and beliefs had great validity in defining the world around him. The not-so-startling leap

was an increasing realization that if our values had validity for ourselves, then it was quite probable that our clients held beliefs equally expressive of their hopes and wishes for themselves and their children. While the values of the community at large were being transmitted to children through parents and caregivers, we had not come to grips with what these were and the persuasive impact they had. While this should have been obvious, since we had all taken introductory anthropology, it was completely overlooked in our haste to implant what we defined as good mental health in the community. Our problems of misunderstanding, misinterpretation, and missed opportunities possibly had sprung less from dynamic sources of resistance as from our lack of appreciation for the various acculturation-socialization processes in the communities we served.

Since our acknowledgement of the dangers as well as the frustrations in selling pre-packaged mental health to the citizenery, we have reconceptualized and redefined our relationships with the consumers. We believe the following steps are of value for any group attempting to begin a primary prevention program.

1). Attempt to articulate to yourself and your co-professionals what your own values and attitudes are concerning behavioral-emotional functioning of young children. Try to make these beliefs systems as explicit as possible.

2). Never try to anticipate before what the particular beliefs of consumers will be. Anticipation often leads to selective filtering or self-confirming prophecies.

3). Before attempting to make any interventions in the community try to survey as many potential consumers as possible. Try to help consumers articulate their wishes, fears, and values for their children both in the short-run and for the long-term.

4). Try to understand the historical forces at work in a community that have led to the establishment of various beliefs and the possible forces at work which may be attempting to change these.

5). Try to determine which values are widely shared or communal in nature and which are idiosyncratic to certain persons or sub-groups.

6). Attempt to be explicit with consumers as to what your personal attitudes and values are concerning children. Do not keep your beliefs under wraps in hope that you will seduce others to your point of view.

7). Start to build preventive programs around points of convergence between professionals and consumers and always articulate the divergent issues confronting both groups.

The authors believe that much of what is at issue in primary prevention programs represent widely shared values among mental health professionals and these have not been submitted to rigorous emperical validation, if indeed that is even possible. The possibility for the professional to attempt to substitute his values without understanding clearly what he is trying to modify in the population is always present. Consistent attempts on the part of professionals to understand the long term goals of a community is a must and consensus between consumers and professionals on mutual interests and concerns must be constantly sought. This is especially important in the beginning stages of community programs.